한울 종합 복지관
Hanul Family Alliance

HANUL HOME CARE SERVICE FUNCTIONAL SCREEN

A. APPLICANT'S BASIC INFORMATION

Name (First)	**(Middle)**	**(Last)**

Gender	**Social Security Number**	**Date of Birth (mm/dd/yyyy)**
□ Male □ Female □ Other: _____		

Address

City	**State**	**Zip**

Telephone: Home	**Telephone: Cell**
( )	( )

B. DEMOGRAPHICS

Medical Insurance *(Check all boxes that apply)*

□ Medicare □ Medicaid □ Private Insurance □ TRICARE (VA)
□ Insurance through employment □ No Insurance □ Other: _____

Race	**Primary language**
□ American Indian or Alaska Native	□ English
□ African American	□ Spanish
□ Asian	□ Russian
□ Caucasian	□ Korean
□ Other: _____	□ Other: _____

C. EMERGENCY CONTACT

Name (First)	**(Middle)**	**(Last)**

Address

City	**State**	**Zip**

Telephone (Home)	**Telephone (Cell)**	**Relationship w/ client**
( )	( )	

Notes:

D. LIVING SITUATION

1. Own home or Apartment
□ Live alone
□ Live with spouse/partner/family
□ Live with non-relatives
□ Live with live-in paid caregiver(s)

2. Someone else's home or Rent
□ Family owned/rented home
□ Non-relative owned/rented home
□ Subsidized housing
□ Private Rent/lease by client

E. FUNCTIONAL LIMITATION

HOME CARE	Level of Functional Limitation	Services by
EATING	□ Independent □ Need help with equipment/devices □ Need help with caregiver's assistance	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
MEAL PREPARATION	□ Independent □ Need help with caregiver's assistance weekly or less often □ Need help with caregiver's assistance 2~7 times a week □ Need help with every meal	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
MAKING AND CHANING BEDS	□ Independent □ Need help with caregiver's assistance weekly or less □ Need help with caregiver's assistance more than once a week	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
DUSTING/ VACUUMING	□ Independent □ Need help with caregiver's assistance weekly or less □ Need help with caregiver's assistance more than once a week	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
WASHING DISHES	□ Independent □ Need help with caregiver's assistance weekly or less □ Need help with caregiver's assistance more than once a week	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
LIGHT CLEANING	□ Independent □ Need help with caregiver's assistance weekly or less □ Need help with caregiver's assistance more than once a week	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
LAUNDRY	□ Independent □ Need help with caregiver's assistance weekly or less □ Need help with caregiver's assistance more than once a week	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
TAKING OUT GARBAGES	□ Independent □ Need help with caregiver's assistance weekly or less □ Need help with caregiver's assistance more than once a week	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
ERRANDS/ SHOPPING	□ Independent □ Need help with caregiver's assistance weekly or less □ Need help with caregiver's assistance more than once a week	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____

PERSONAL CARE	Level of Functional Limitation	Services by
DRESSING	□ Independent □ Need help without caregiver's assistance weekly or less □ Need help with caregiver's assistance every time	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
BATHING	**Devices using:** □ Uses Grab Bar(s) □ Uses Shower Chair □ Uses Tub Bench □ Uses Mechanical Lift **Level of Functional Limitation** □ Independent □ Need help without caregiver's help □ Need help with caregiver's help	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
GROOMING/NAIL CARE	□ Independent □ Need help without caregiver's assistance weekly or less □ Need help with caregiver's assistance once a week	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
DENTAL CARE	□ Independent □ Need help without caregiver's assistance weekly or less □ Need help with caregiver's assistance once a week	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
TOILETING ASSISTANCE	**1. Device using:** □ No device using □ Uses Grab Bar(s) □ Uses commode or other Adaptive Equipment □ Uses Urinary Catheter □ Has Ostomy □ Receives regular Bowel Program **2. Incontinence** □ Does not have incontinence □ Has incontinence less than daily but at least once per week □ Has incontinence daily	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
TELEPHONE	**1. Ability to use Phone** □ Independent □ Lacks cognitive or physical abilities to use phone independently **2. Access to Phone** □ Currently has working telephone or access to one □ Has no phone and no access to a phone	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
MOBILITY IN HOME	□ Independent □ Uses Cane in Home □ Uses Wheelchair or Scooter in Home □ Has Prosthesis □ Uses Quad-Cane in Home □ Uses Clutches in Home □ Uses Walker in Home	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____

PERSONAL CARE	Level of Functional Limitation	Services by
TRANSFERRING	□ Independent □ Uses Grab Bar(s) □ Uses Transfer Board □ Uses Trapeze □ Uses Mechanical lift (not a lift chair)	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
MEDICATION REMINDER	□ No medications □ Independent □ Need some help 1~2 days per week or less often □ Needs help at least once a day. Client **CAN** direct the task and can make decisions regarding each medication □ Needs help at least once a day. Client **CANNOT** direct the task and can make decisions regarding each medication; is cognitively unable to follow through without another person to administer each medication	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
COMPANIONSHIP	□ Can be left alone □ CANNOT be left alone. Need somebody to do light monitoring □ CANNOT be left alone. Need somebody all time.	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
ESCORT/ TRANSPORTATION	□ Client drives owned vehicle □ Client drives vehicle but there are serious safety concerns □ Client CANNOT drive due to physical, psychological, or cognitive impairment. Includes no driver's license due to medical problems □ Client does not drive due to other reasons: _____	□ Family member □ Paid caregiver □ Friends/neighbors □ Other _____
Notes:		

F. HEALTH CONDITIONS AND DISEASES

YES	NO	HEALTH CONDITIONS AND DISEASES	MEDICAL HISTORY/CONDITION	SUPPORT RECEIVED
☐ Y	☐ N	Allergy to Food/Medications		
☐ Y	☐ N	Alzheimer's/ Confusion/ Dementia		
☐ Y	☐ N	Arthritis/ Osteoporosis		
☐ Y	☐ N	Cancer		
☐ Y	☐ N	Dental Needs		
☐ Y	☐ N	Diabetes		
☐ Y	☐ N	Visual Impairments		
☐ Y	☐ N	Gastrointestinal Disorders		
☐ Y	☐ N	Hearing Problems		
☐ Y	☐ N	Heart Disease/ High Blood Pressure		
☐ Y	☐ N	Infectious Disease/ Tuberculosis		
☐ Y	☐ N	Kidney/ Bladder Problems		
☐ Y	☐ N	Liver Disease		
☐ Y	☐ N	Neurological Disease		
☐ Y	☐ N	Prostate/ Incontinent Problems		
☐ Y	☐ N	Respiratory Diseases		
☐ Y	☐ N	Sleep Disorders/ Insomnia		
☐ Y	☐ N	Speech Difficulties		
☐ Y	☐ N	Stroke/ Paralysis		
☐ Y	☐ N	Pain		
☐ Y	☐ N	Others		

G. COMMUNICATION AND COGNITION

1. Communication:
Includes the ability to express oneself in one's own language, including non-English languages and American Sign Language (ASL) or other generally recognized non-verbal communication. This includes the use of assistive technology

- □ Can fully communicate with no impairment or only minor impairment (For example, slow speech)
- □ Can fully communicate with the use of assistive device
- □ Can communicate only basic needs to others
- □ No effective communication

2. Memory Loss

- □ No Memory impairments evident during screening process
- □ Short-term memory loss (seems unable to recall things a few minutes up to 24 hours later)
- □ Unable to remember things over several days or weeks
- □ Long term memory loss (seems unable to recall distant past)
- □ Memory impairments are unknown or unable to determine.
  Explain Why: _____

3. Cognitive for Daily Decision Making

- □ Independent
- □ Person can make safe decisions in familiar/routine situations, but needs some help with decision-making when faced with new tasks or situations
- □ Person needs help with reminding, planning, or adjusting routine, even with familiar routine
- □ Person needs help from another person most or all of the time

Notes:

H. BEHAVIORAL HEALTH

1. Wandering
Defined as a person with cognitive impairments leaving residence/immediate area without informing others. Person may still exhibit wandering behavior even if elopement is impossible due to, for example, facility security systems.

- □ Does not wander
- □ Daytime wandering but sleeps nights
- □ Wanders at night, or day and night

2. Offensive or Violent Behaviors

- □ No offensive or violent behaviors demonstrated
- □ Some self-injurious behaviors require interventions
- □ Some offensive or violent behaviors to others require occasional interventions
- □ Offensive or violent behaviors require intensive one-on-one interventions

3. Mental Health Needs

□ No mental health problems or needs evident
□ No current diagnosis. Person may be at risk and in deed of mental health services
□ Person has a current diagnosis of mental illness

4. Substance Use Disorder

□ No substance use issues or diagnosis evident at this time
□ No current diagnosis.
□ Client has a current diagnosis of substance use disorder

Notes:

I. SUMMARY OF NEEDS IDENTIFIED

J. SCREEN COMPLETION

Date of Screen Completion: _____

Name of Screener: _____

Signature of Screener: _____